Sound Dermatology

INTAKE FORM

First Name:_____ **Middle Name:**_____ **Last Name:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Date of Birth:_____ **Email Address:** _____
Preferred Phone:_____ □ Home □ Mobile □ Work
Alternative Phone: _____ □ Home □ Mobile □ Work
□ Check this box if it is OK to leave a detailed message on your voicemail
□ By checking this box, you authorize Sound Dermatology to contact you using the phone numbers or email address provided above for appointment reminders, scheduling updates, and other limited healthcare communications. These communications may include voicemail, text message, or email. You understand that electronic communication may not always be secure.

DEMOGRAPHICS

Sex assigned at Birth: □ Male □ Female □ Prefer not to answer
Gender Identity: □ Male □ Female □ Non-binary □ Prefer not to answer □ Other: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered □ Prefer not to answer
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer not to answer
Race (please select all that apply): □ Black or African American □ American Indian or Alaska Native (Native American)
□ Native Hawaiian or Other Pacific Islander □ Asian □ White □ Prefer not to answer □ Other: _____
Employer:_____ **Job Title:**_____
Primary Care Provider:_____ **Preferred Pharmacy:** _____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone Number:_____

INSURANCE

Primary Insurance Company Name:_____ **Policy Holder:** □ Self □ Other:
Member ID: _____ Group Number: _____
Policy Holder Name:_____DOB:_____Relationship to Patient:_____
Secondary Insurance Company Name:_____ **Policy Holder:** □ Self □ Other:
Member ID: _____ Group Number: _____
Policy Holder Name:_____DOB:_____Relationship to Patient:_____

PERSON RESPONSIBLE FOR PAYMENT (Required for patients under 18 years old)

□ Self □ Other - Name: _____ Date of Birth:_____
Address:_____ Phone:_____ Relationship:_____

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I authorize payment of authorized insurance benefits directly to Sound Dermatology for services rendered. I also authorize Sound Dermatology to release medical information necessary to process insurance claims and determine payable benefits. I understand that I am financially responsible for all charges incurred, regardless of insurance coverage or benefit determination. All biopsies are submitted for histopathologic examination. Sound Dermatology utilizes Pro-Path Dermatopathology for histopathologic review unless otherwise required by your insurance plan. Pathology services are billed separately by the dermatopathologist and are not included in Sound Dermatology's charges.

_____ _____
Signature of Patient/Personal Representative Printed Name

_____ _____
Relationship to Patient Date

Sound Dermatology

Medical/Surgical History Form

Name: _____ Date of Birth: _____

Past Medical History

Please indicate whether you have had or currently have any of the following medical conditions:

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Autoimmune Disease
- □ Benign Prostatic Hyperplasia
- □ Bleeding Disorder
- □ Blood Clots
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ Renal (Kidney) Disease
- □ GERD (Acid Reflux)
- □ Hepatitis
- □ Hypertension (High Blood Pressure)
- □ HIV/AIDS
- □ High Cholesterol
- □ Hypothyroidism
- □ Hyperthyroidism
- □ Inflammatory Bowel Disease (UC/Crohn's)
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Rheumatoid Arthritis (RA)
- □ Seizure Disorder
- □ Stroke
- □ No Previous Medical History
- □ Other (please write in below):

_____
_____
_____
_____
_____
_____

Past Surgical History

Please indicate if you have had any of the following surgical procedures:

- □ Bone Marrow Transplant
- □ Cancer Surgery
  Type: _____
- □ Breast Surgery
- □ Cardiac Surgery
- □ Colon Surgery
- □ Coronary Stent Placement
- □ Joint Replacement
  Which Joint: □ Shoulder □ Hip □ Knee
  Which Side: □ Left □ Right □ Both
- □ Lymph Node Dissection
- □ Bariatric Surgery
- □ Hysterectomy
- □ Oophorectomy
- □ Thyroid Surgery
- □ Radiation Therapy
- □ No Prior Surgeries
- □ Other (please write in below)

_____
_____
_____
_____

Sound Dermatology

Dermatologic History

Please indicate if you have had any of the following dermatologic conditions or surgeries:

□ Acne
□ Actinic Keratoses
□ Asthma
□ Atypical Moles (Dysplastic Nevus)
□ Eczema
□ History of Basal Cell Carcinoma
□ History of Squamous Cell Carcinoma
□ History of Skin Cancer (type unspecified)
□ History of Mohs Surgery
□ Keloids (Hypertrophic Scarring)
□ Personal History of Melanoma
□ Psoriasis
□ Seasonal Allergies (Hay Fever)
□ Tanning Bed Use
□ No Previous Dermatologic History

Do you regularly use sunscreen?
□ Yes □ No
If yes, what SPF? _____

Do you have a family history of Melanoma?
□ Yes □ No
If yes, which relative: _____

Current Medications

□ No Current Medications

Please list all current medications, including prescriptions, over-the-counter medications, and supplements below (you may ask for an additional sheet if needed):

Medication Name	Dosage (mg, mcg, mL)	Route (Oral, injection, topical)	Frequency

Allergies

□ No Known Drug Allergies

Please list any medication allergies and reactions if known below (please include any topical medications, adhesives, latex, as well as oral or injectable medications):

Allergy	Reaction (Example: rash, hives, swelling, difficulty breathing, nausea)

Tobacco Use

□ I do not use tobacco
□ I previously used tobacco (Year Stopped: _____)
□ I currently use tobacco
If current, type: □ Cigarettes □ Vaping □ Cigars □ Smokeless
Packs per day (if applicable): _____

Alcohol Use

□ I do not drink alcohol
□ I previously drank alcohol
□ I currently drink alcohol
If current, approximately how many drinks per week? _____

Why We Ask: Tobacco and alcohol use may affect certain dermatologic conditions, wound healing, and medication safety. This information helps us provide safe and appropriate care.

Sound Dermatology

FAMILY AND OTHER INDIVIDUALS INVOLVED IN YOUR CARE

I authorize Sound Dermatology to verbally disclose my medical, financial, and appointment information to the individuals listed below, unless otherwise specified. This may include, but is not limited to, information related to my medical condition, treatment, billing, insurance, and appointment scheduling.

□ I do NOT authorize Sound Dermatology to disclose my information to anyone.

Name of Individual	Relationship	Phone Number

□ Include Emergency Contact(s) listed on Intake Form

This authorization will remain in effect unless revoked in writing by the patient.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Printed name of patient or responsible party Relationship to patient

Sound Dermatology

CONSENT FOR TREATMENT

Sound Dermatology

I voluntarily consent to evaluation, examination, and medical treatment by the physicians, providers, and clinical staff of Sound Dermatology.

I understand that medical care may include, but is not limited to:

- Dermatologic examination
- Diagnostic testing
- Minor medical procedures (such as skin biopsies, cryotherapy, injections, or lesion removal)
- Prescribing medications
- Laboratory testing or pathology services
- Referral to other healthcare providers when appropriate

Dermatologic examinations may require visualization of areas of skin normally covered by clothing in order to provide appropriate medical evaluation.

The nature and purpose of my care will be explained to me when appropriate, and I will have the opportunity to ask questions about recommended treatments or procedures.

I understand that:

- The practice of medicine is not an exact science and no guarantees have been made regarding the results of my treatment.
- I have the right to accept or refuse recommended care or treatment at any time.
- Additional informed consent may be required for certain procedures or treatments.

If I am signing as the parent, guardian, or personal representative of the patient, I certify that I have the legal authority to consent to medical treatment on behalf of the patient.

Consent for Treatment of Minors

For patients under the age of 18, consent must be provided by a parent or legal guardian unless otherwise permitted by law.

Consent to Treat

By signing below, I acknowledge that I have read and understand this consent and authorize Sound Dermatology to provide medical care and treatment as described above.

Signature of Patient/Personal Representative: _____

Printed Name of Patient/Representative: _____

Relationship to Patient (if applicable): _____ Date: _____

Sound Dermatology

Clinical Photography Consent Form

Clinical photographs may be taken during your visit to document skin conditions, monitor treatment progress, or assist in medical decision-making. These images may become part of your confidential medical record.

Medical Record Photography

I authorize Sound Dermatology to take clinical photographs of my skin condition for purposes of:

- Documentation of my medical condition
- Monitoring treatment progress
- Medical consultation or referral
- Inclusion in my medical record

These photographs will be stored securely and will be treated as part of my Protected Health Information (PHI) in accordance with applicable privacy laws.

□ **I consent to clinical photographs being taken and stored in my medical record.**
□ **I decline clinical photographs as part of my medical record.**

Educational Use (Optional)

Photographs may occasionally be used for educational purposes such as medical teaching, professional presentations, or academic publications. Identifying information will be removed whenever possible.

□ **I authorize use of my photographs for educational purposes.**
□ **I do not authorize educational use of my photographs.**

Marketing / Public Use (Optional)

Separate permission is required before photographs are used for marketing or public-facing materials such as:

- Website
- Social media
- brochures or advertisements
- other promotional materials

□ **I authorize Sound Dermatology to use my photographs for marketing purposes.**
□ **I do not authorize marketing use of my photographs.**

If authorization is given, reasonable efforts will be made to remove identifying features when possible.

Withdrawal of Consent

I understand that I may withdraw my authorization for future use of photographs at any time by submitting a written request to Sound Dermatology. Withdrawal will not affect photographs already used or published before the request was received.

Signature of Patient/Personal Representative: _____

Printed Name: _____ Date: _____

Relationship to Patient (if applicable): _____